



FOR AGENT USE ONLY (Please print legibly)			
Agency Code	_____	_____	_____
Agent Number	_____	_____	_____
Agent Name	_____		

# InstaCare<sup>SM</sup> Contract Schedule and Application

## **A Reason for Application**

- \_\_\_ I am a new applicant, not currently a Blue Cross and Blue Shield of Minnesota (Blue Cross) member
- \_\_\_ I have or have had other Blue Cross coverage and I am applying for InstaCare. Blue Cross ID number: \_\_\_\_\_

## **Application instructions**

1. Please complete this entire application including all explanations as requested. Print clearly using black or blue ink. Incomplete applications will be returned to you to be completed.
2. Sign and date this application.
3. If you or the agent mail the application, the effective date is the day we receive the application in our home office (Eagan location) or the requested effective date, whichever is later. If you or the agent deliver the application to our home office, the effective date is the day after the receipt date in our home office or the requested effective date, whichever is later. If you submit an electronic application, the effective date is the day after the receipt date of the electronic application in our home office or the requested effective date, whichever is later. The effective date cannot be greater than 60 days after the signature date.
4. Submit this application with full payment to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164. If paying by check, make your check payable to Blue Cross and Blue Shield of Minnesota.
5. Agent retains the pink copy of the application, attaches the yellow copy to the contract for the subscriber, and mails the original to Blue Cross.

## **General application information**

- You must be a resident of Minnesota.
- Applicants must be age 19 through age 64 years to apply.
- **Persons at least 90 days old and under the age of 19 are eligible only as dependents under an eligible parent/legal guardian applicant.**
- Previous short-term coverage - State law limits short-term coverage to a maximum of 365 days, combined from all carriers, for any individual in any 555 day period. You will not be eligible for coverage if the InstaCare contract term you selected will exceed this limit.
- **Preexisting conditions - InstaCare does not provide coverage for any preexisting conditions. A preexisting condition is any injury, illness or condition for which you have had medical treatment, symptoms or any manifestations of the injury, illness or condition before the effective date of this contract. Any injury, illness or condition treated under a previous InstaCare contract is a preexisting condition and will not be covered under a new InstaCare contract. Even if you have not been to a doctor or been diagnosed or treated for a symptom, an illness evidenced by that symptom is not covered.**
- You may be contacted from Blue Cross for additional information.

## **Contract issuance**

- This contract is issued for a specific number of days as stated in section C of the Contract Schedule and Application (30, 60 or 90 days). This contract cannot be renewed. You may be eligible to apply for a new contract term which requires you to complete a new application.
- If you have not received your identification (ID) card within 14 days, please call (651) 662-5030 or toll-free 1-800-531-6685.

## **How to contact us**

- Please contact your agent for assistance or call 651-662-5050 or 1-800-262-0823 and one of our Blue Cross representatives will be happy to assist you.

**B Personal information**

Name \_\_\_\_\_ Legal Marital Status \_\_\_\_\_ Single \_\_\_\_\_ Married  
First Last

Social Security Number \_\_\_\_\_ Email address \_\_\_\_\_

Birth date \_\_\_\_\_ Sex \_\_\_\_\_ Male \_\_\_\_\_ Female  
mm dd yyyy

Address \_\_\_\_\_  
Street including Apt Number

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred telephone number ( ) \_\_\_\_\_ Alternate telephone number ( ) \_\_\_\_\_

Starting with Applicant, list each family member applying for coverage:

First	Name Last	Number of Days of Short-term Coverage in last 555 days	Social Security Number	Relationship to Applicant	Birth Date mm/dd/yyyy	Sex M/F
				Applicant		

Additional family members on attached page

**C Plan selection**

**COVERAGE FOR SUBSTANCE ABUSE IS INCLUDED IN THE CONTRACT. I WANT TO DECLINE COVERAGE FOR THIS BENEFIT, WHICH WILL RESULT IN A PREMIUM REDUCTION:**  Yes  No

**Contract Term (select one)**  30 days  60 days  90 days

Deductible and Out-of-Pocket Maximum per contract term (select one):

**In-Network:** \$300 Individual Deductible (\$900 Family Deductible) / \$1,000 Individual Out-of-Pocket (\$3,000 Family Out-of-Pocket)  
**Out-of-Network:** \$900 Individual Deductible (\$2,700 Family Deductible) / \$5,400 per Individual Out-of-Pocket

**In-Network:** \$500 Individual Deductible (\$1,500 Family Deductible) / \$1,500 Individual Out-of-Pocket (\$4,500 Family Out-of-Pocket)  
**Out-of-Network:** \$1,500 Individual Deductible (\$4,500 Family Deductible) / \$9,000 per Individual Out-of-Pocket

**In-Network:** \$1,000 Individual Deductible (\$3,000 Family Deductible) / \$3,000 Individual Out-of-Pocket (\$9,000 Family Out-of-Pocket)  
**Out-of-Network:** \$3,000 Individual Deductible (\$9,000 Family Deductible) / \$18,000 per Individual Out-of-Pocket

**D Payment**

Total amount paid with this application \$ \_\_\_\_\_ (You must submit full payment)

**E Coordination of Benefits**

Will you or any family member on this application have other health or medical coverage, including Medicare, once this policy is in force?  Yes  No

If the response is Yes, you may be contacted for more information.

**F Effective date of coverage**

- Requested Effective Date \_\_\_\_\_.
- If you or the agent mail the application, the effective date is the day we receive the application in our *home office* or the requested effective date, whichever is later.
- If you or the agent deliver the application to our *home office*, the effective date is the day after the receipt date in our *home office* or the requested effective date, whichever is later.
- If you submit an electronic application, the effective date is the day after the receipt date of the electronic application in our *home office* or the requested effective date, whichever is later.
- The effective date cannot be greater than 60 days after the signature.

**G Authorization and representation**

Important information about this application for coverage. Read this section, sign and date the application.

I represent all applicants for this coverage:

- have not been declined for health coverage within the past year as a result of a medical condition;
- are not an expectant father, are not currently pregnant and do not have a wife or daughter (even if not applying) who is currently pregnant;
- are not in the process of adopting a child;
- are not currently confined in any health care facility;
- are not less than 90 days of age; and
- live in Minnesota.

I understand coverage is limited and InstaCare is a nonqualified plan. I also understand InstaCare does not provide coverage for any preexisting conditions. A preexisting condition is any injury, illness or condition for which I have had medical treatment, symptoms or any manifestations of the injury, illness or condition before the effective date of this contract.

I understand each InstaCare contract is a separate contract and cannot be renewed. I also understand that if I purchase another InstaCare contract, I will NOT be covered for any illness resulting from symptoms, any manifestations of the injury, illness or condition that I had during any previous InstaCare contract. I will not be covered even if that illness or injury was covered under my previous InstaCare contract. Any conditions covered under my previous InstaCare contract are considered preexisting conditions under any future InstaCare contract.

When I provide a check as payment, I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my payment and I will not receive my check back from my financial institution.

I acknowledge receipt of the notice concerning my rights under the Minnesota Life and Health Insurance Guaranty Association.

**NOTE: YOUR FULL PAYMENT MUST ACCOMPANY THIS APPLICATION. LACK OF FULL PAYMENT WILL VOID THIS APPLICATION.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature